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TITLE 42--PUBLIC HEALTH

HUMAN SERVICES

PART 418--**HOSPICE** CARE

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Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

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Source: 48 FR 56026, Dec. 16, 1983, unless otherwise noted.

Subpart A--General Provision and Definitions

Sec. 418.1 Statutory basis.

This part implements section 1861(dd) of the Social Security Act. Section 1861(dd) specifies services covered as **hospice** care and the conditions that a **hospice** program must meet in order to participate in the Medicare program. The following sections of the Act are also pertinent:

- (a) Sections 1812(a) (4) and (d) of the Act specify eligibility requirements for the individual and the benefit periods.
- (b) Section 1813(a) (4) of the Act specifies coinsurance amounts.

(c) Sections 1814(a)(7) and 1814(i) of the Act contain conditions and limitations on coverage of, and payment for, **hospice** care.

(d) Sections 1862(a)(1), (6) and (9) of the Act establish limits on **hospice** coverage.

[48 FR 56026, Dec. 16, 1983, as amended at 57 FR 36017, Aug. 12, 1992]

Sec. 418.2 Scope of part.

Subpart A of this part sets forth the statutory basis and scope and defines terms used in this part. Subpart B specifies the eligibility requirements and the benefit periods. Subpart C specifies conditions of participation for hospices. Subpart D describes the covered services and specifies the limits on services covered as **hospice** care. Subpart E specifies the reimbursement methods and procedures. Subpart F specifies coinsurance amounts applicable to **hospice** care.

Sec. 418.3 Definitions.

For purposes of this part--

Attending physician means a physician who--

(a) Is a doctor of medicine or osteopathy; and

(b) Is identified by the individual, at the time he or she elects to receive **hospice** care, as having the most significant role in the determination and delivery of the individual's medical care.

Bereavement counseling means counseling services provided to the individual's family after the individual's death.

Cap period means the twelve-month period ending October 31 used in the application of the cap on overall **hospice** reimbursement specified in Sec. 418.309.

Employee means an employee (defined by section 210(j) of the Act) of the **hospice** or, if the **hospice** is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the **hospice** unit. ``Employee'' also refers to a volunteer under the jurisdiction of the **hospice**.

Hospice means a public agency or private organization or subdivision of either of these that--is primarily engaged in providing care to terminally ill individuals.

Physician means physician as defined in Sec. 410.20 of this chapter.

Representative means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of **hospice** care on behalf of a terminally ill individual who is mentally or physically incapacitated.

Social worker means a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education.

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

[48 FR 56026, Dec. 16, 1983, as amended at 52 FR 4499, Feb. 12, 1987; 50 FR 50834, Dec. 11, 1990]

Subpart B--Eligibility, Election and Duration of Benefits

Sec. 418.20 Eligibility requirements.

In order to be eligible to elect **hospice** care under Medicare, an individual must be--

- (a) Entitled to Part A of Medicare; and
- (b) Certified as being terminally ill in accordance with Sec. 418.22.

Sec. 418.21 Duration of **hospice** care coverage--Election periods.

(a) Subject to the conditions set forth in this part, an individual may

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elect to receive **hospice** care during one or more of the following election periods:

- (1) An initial 90-day period.
 - (2) A subsequent 90-day period.
 - (3) A subsequent 30-day period.
 - (4) A subsequent extension period of unlimited duration during the individual's lifetime.
- (b) The periods of care are available in the order listed and may be elected separately at different times.

[55 FR 50834, Dec. 11, 1990, as amended at 57 FR 36017, Aug. 12, 1992]

Sec. 418.22 Certification of terminal illness.

(a) Timing of certification--(1) General rule. The **hospice** must obtain written certification of terminal illness for each of the periods listed in Sec. 418.21, even if a single election continues in effect for two, three, or four periods, as provided in Sec. 418.24(c).

(2) Basic requirement. Except as provided in paragraph (a)(3) of this section, the **hospice** must obtain the written certification no later than two calendar days after the period begins.

(3) Exception. For the initial 90-day period, if the **hospice** cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

(b) Content of certification. The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

(c) Sources of certification. (1) For the initial 90-day period, the **hospice** must obtain written certification statements (and oral certification statements if required under paragraph (a)(3) of this section) from--

(i) The medical director of the **hospice** or the physician member of the **hospice** interdisciplinary group; and

(ii) The individual's attending physician if the individual has an attending physician.

(2) For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph (c)(1)(i) of this section.

(d) Maintenance of records. **Hospice** staff must--

(1) Make an appropriate entry in the patient's medical record as soon as they receive an oral certification; and

(2) File written certifications in the medical record.

[55 FR 50834, Dec. 11, 1990, as amended at 57 FR 36017, Aug. 12, 1992]

Sec. 418.24 Election of **hospice** care.

(a) Filing an election statement. An individual who meets the eligibility requirement of Sec. 418.20 may file an election statement with a particular **hospice**. If the individual is physically or mentally incapacitated, his or her representative (as defined in Sec. 418.3) may file the election statement.

(b) Content of election statement. The election statement must include the following:

(1) Identification of the particular **hospice** that will provide care to the individual.

(2) The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of **hospice** care, as it relates to the individual's terminal illness.

(3) Acknowledgement that certain Medicare services, as set forth in paragraph (d) of this section, are waived by the election.

(4) The effective date of the election, which may be the first day of **hospice** care or a later date, but may be no earlier than the date of the election statement.

(5) The signature of the individual or representative.

(c) Duration of election. An election to receive **hospice** care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual--

(1) Remains in the care of a **hospice**; and

(2) Does not revoke the election under the provisions of Sec. 418.28.

(d) Waiver of other benefits. For the duration of an election of **hospice** care, an individual waives all rights to Medicare payments for the following services:

(1) **Hospice** care provided by a **hospice** other than the **hospice** designated by

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the individual (unless provided under arrangements made by the designated **hospice**).

(2) Any Medicare services that are related to the treatment of the terminal condition for which **hospice** care was elected or a related condition or that are equivalent to **hospice** care except for services--

(i) Provided by the designated **hospice**:

(ii) Provided by another **hospice** under arrangements made by the designated **hospice**; and

(iii) Provided by the individual's attending physician if that physician is not an employee of the designated **hospice** or receiving compensation from the **hospice** for those services.

(e) Re-election of **hospice** benefits. If an election has been revoked in accordance with Sec. 418.28, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

[55 FR 50834, Dec. 11, 1990]

Sec. 418.28 Revoking the election of **hospice** care.

(a) An individual or representative may revoke the individual's election of **hospice** care at any time during an election period.

(b) To revoke the election of **hospice** care, the individual or representative must file a statement with the **hospice** that includes the following information:

(1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of **hospice** care for the remainder of that election period.

(2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

(c) An individual, upon revocation of the election of Medicare coverage of **hospice** care for a particular election period--

(1) Is no longer covered under Medicare for **hospice** care;

(2) Resumes Medicare coverage of the benefits waived under Sec. 418.24(e) (2); and

(3) May at any time elect to receive **hospice** coverage for any other **hospice** election periods that he or she is eligible to receive.

Sec. 418.30 Change of the designated **hospice**.

(a) An individual or representative may change, once in each election period, the designation of the particular **hospice** from which **hospice** care will be received.

(b) The change of the designated **hospice** is not a revocation of the election for the period in which it is made.

(c) To change the designation of **hospice** programs, the individual or representative must file, with the **hospice** from which care has been received and with the newly designated **hospice**, a statement that includes the following information:

(1) The name of the **hospice** from which the individual has received care and the name of the **hospice** from which he or she plans to receive care.

(2) The date the change is to be effective.

Subpart C--Conditions of Participation--General Provisions and Administration

Sec. 418.50 Condition of participation--General provisions.

(a) Standard: Compliance. A **hospice** must maintain compliance with the conditions of this subpart and subparts D and E of this part.

(b) Standard: Required services. A **hospice** must be primarily engaged in providing the care and services described in Sec. 418.202, must provide bereavement counseling and must--

(1) Make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis;

(2) Make all other covered services available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions; and

(3) Provide these services in a manner consistent with accepted standards of practice.

(c) Standard: Disclosure of information. The **hospice** must meet the

disclosure

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of information requirements at Sec. 420.206 of this chapter.

[48 FR 56026, Dec. 16, 1983, as amended at 55 FR 50834, Dec. 11, 1990]

Sec. 418.52 Condition of participation--Governing body.

A **hospice** must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the **hospice's** total operation. The governing body must designate an individual who is responsible for the day to day management of the **hospice** program. The governing body must also ensure that all services provided are consistent with accepted standards of practice.

Sec. 418.54 Condition of participation--Medical director.

The medical director must be a **hospice** employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the **hospice's** patient care program.

Sec. 418.56 Condition of participation--Professional management.

Subject to the conditions of participation pertaining to services in Secs. 418.80 and 418.90, a **hospice** may arrange for another individual or entity to furnish services to the **hospice's** patients. If services are provided under arrangement, the **hospice** must meet the following standards:

(a) Standard: Continuity of care. The **hospice** program assures the continuity of patient/family care in home, outpatient, and inpatient settings.

(b) Standard: Written agreement. The **hospice** has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following:

(1) Identification of the services to be provided.

(2) A stipulation that services may be provided only with the express authorization of the **hospice**.

(3) The manner in which the contracted services are coordinated, supervised, and evaluated by the **hospice**.

(4) The delineation of the role(s) of the **hospice** and the contractor in the admission process, patient/family assessment, and the interdisciplinary group care conferences.

(5) Requirements for documenting that services are furnished in accordance with the agreement.

(6) The qualifications of the personnel providing the services.

(c) Standard: Professional management responsibility. The **hospice** retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications of this part, and in accordance with the patient's plan of care and the other requirements of this part.

(d) Standard: Financial responsibility. The **hospice** retains responsibility for payment for services.

(e) Standard: Inpatient care. The **hospice** ensures that inpatient care is furnished only in a facility which meets the requirements in Sec. 418.98 and its arrangement for inpatient care is described in a

legally binding written agreement that meets the requirements of paragraph (b) and that also specifies, at a minimum--

(1) That the **hospice** furnishes to the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;

(2) That the inpatient provider has established policies consistent with those of the **hospice** and agrees to abide by the patient care protocols established by the **hospice** for its patients;

(3) That the medical record includes a record of all inpatient services and events and that a copy of the discharge summary and, if requested, a copy of the medical record are provided to the **hospice**;

(4) The party responsible for the implementation of the provisions of the agreement; and

(5) That the **hospice** retains responsibility for appropriate **hospice** care training of the personnel who provide the care under the agreement.

[48 FR 56026, Dec. 16, 1983; 48 FR 57282, Dec. 29, 1983]

Sec. 418.58 Condition of participation--Plan of care.

A written plan of care must be established and maintained for each individual admitted to a **hospice** program,

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and the care provided to an individual must be in accordance with the plan.

(a) Standard: Establishment of plan. The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(b) Standard: Review of plan. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

(c) Standard: Content of plan. The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

Sec. 418.60 Condition of participation--Continuation of care.

A **hospice** may not discontinue or diminish care provided to a Medicare beneficiary because of the beneficiary's inability to pay for that care.

Sec. 418.62 Condition of participation--Informed consent.

A **hospice** must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as **hospice** care during the course of the illness has been obtained for every individual, either from the individual or representative as defined in Sec. 418.3.

Sec. 418.64 Condition of participation--Inservice training.

A **hospice** must provide an ongoing program for the training of its

employees.

Sec. 418.66 Condition of participation--Quality assurance.

A **hospice** must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care and care provided under arrangements. The findings are used by the **hospice** to correct identified problems and to revise **hospice** policies if necessary. Those responsible for the quality assurance program must--

- (a) Implement and report on activities and mechanisms for monitoring the quality of patient care;
- (b) Identify and resolve problems; and
- (c) Make suggestions for improving patient care.

Sec. 418.68 Condition of participation--Interdisciplinary group.

The **hospice** must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the **hospice**.

(a) Standard: Composition of group. The **hospice** must have an interdisciplinary group or groups that include at least the following individuals who are employees of the **hospice**:

- (1) A doctor of medicine or osteopathy.
- (2) A registered nurse.
- (3) A social worker.
- (4) A pastoral or other counselor.

(b) Standard: Role of group. The interdisciplinary group is responsible for--

- (1) Participation in the establishment of the plan of care;
- (2) Provision or supervision of **hospice** care and services;
- (3) Periodic review and updating of the plan of care for each individual receiving **hospice** care; and
- (4) Establishment of policies governing the day-to-day provision of **hospice** care and services.

(c) If a **hospice** has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described in paragraph (b) (4) of this section.

(d) Standard: Coordinator. The **hospice** must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

Sec. 418.70 Condition of participation--Volunteers.

The **hospice** in accordance with the numerical standards, specified in paragraph (e) of this section, uses volunteers, in defined roles, under the supervision of a designated **hospice** employee.

(a) Standard: Training. The **hospice** must provide appropriate orientation

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and training that is consistent with acceptable standards of **hospice** practice.

(b) Standard: Role. Volunteers must be used in administrative or direct patient care roles.

(c) Standard: Recruiting and retaining. The **hospice** must document

active and ongoing efforts to recruit and retain volunteers.

(d) Standard: Cost saving. The **hospice** must document the cost savings achieved through the use of volunteers. Documentation must include--

(1) The identification of necessary positions which are occupied by volunteers;

(2) The work time spent by volunteers occupying those positions; and

(3) Estimates of the dollar costs which the **hospice** would have incurred if paid employees occupied the positions identified in paragraph (d)(1) for the amount of time specified in paragraph (d)(2).

(e) Standard: Level of activity. A **hospice** must document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid **hospice** employees and contract staff. The **hospice** must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, must be recorded.

(f) Standard: Availability of clergy. The **hospice** must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request such visits and must advise patients of this opportunity.

Sec. 418.72 Condition of participation--Licensure.

The **hospice** and all **hospice** employees must be licensed in accordance with applicable Federal, State and local laws and regulations.

(a) Standard: Licensure of program. If State or local law provides for licensing of hospices, the **hospice** must be licensed.

(b) Standard: Licensure of employees. Employees who provide services must be licensed, certified or registered in accordance with applicable Federal or State laws.

Sec. 418.74 Condition of participation--Central clinical records.

In accordance with accepted principles of practice, the **hospice** must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

(a) Standard: Content. Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the **hospice**. Each individual's record contains--

(1) The initial and subsequent assessments;

(2) The plan of care;

(3) Identification data;

(4) Consent and authorization and election forms;

(5) Pertinent medical history; and

(6) Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

(b) Standard; Protection of information. The **hospice** must safeguard the clinical record against loss, destruction and unauthorized use.

Subpart D--Conditions of Participation: Core Services

Sec. 418.80 Condition of participation--Furnishing of core services.

Except as permitted in Sec. 418.83, a **hospice** must ensure that substantially all the core services described in this subpart are routinely provided directly by **hospice** employees. A **hospice** may use contracted staff if necessary to supplement **hospice** employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the **hospice** must maintain professional, financial, and administrative responsibility for the services and must assure that the

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qualifications of staff and services provided meet the requirements specified in this subpart.

[52 FR 7416, Mar. 11, 1987, as amended at 55 FR 50835, Dec. 11, 1990]

Sec. 418.82 Condition of participation--Nursing services.

The **hospice** must provide nursing care and services by or under the supervision of a registered nurse.

(a) Nursing services must be directed and staffed to assure that the nursing needs of patients are met.

(b) Patient care responsibilities of nursing personnel must be specified.

(c) Services must be provided in accordance with recognized standards of practice.

Sec. 418.83 Nursing services--Waiver of requirement that substantially all nursing services be routinely provided directly by a **hospice**.

(a) CMS may approve a waiver of the requirement in Sec. 418.80 for nursing services provided by a **hospice** which is located in a non-urbanized area. The location of a **hospice** that operates in several areas is considered to be the location of its central office. The **hospice** must provide evidence that it was operational on or before January 1, 1983, and that it made a good faith effort to hire a sufficient number of nurses to provide services directly. CMS bases its decision as to whether to approve a waiver application on the following:

(1) The current Bureau of the Census designations for determining non-urbanized areas.

(2) Evidence that a **hospice** was operational on or before January 1, 1983 including:

(i) Proof that the organization was established to provide **hospice** services on or before January 1, 1983;

(ii) Evidence that **hospice**-type services were furnished to patients on or before January 1, 1983; and

(iii) Evidence that the **hospice** care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983.

(3) Evidence that a **hospice** made a good faith effort to hire nurses, including:

(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts;

(ii) Job descriptions for nurse employees;

(iii) Evidence that salary and benefits are competitive for the area; and

(iv) Evidence of any other recruiting activities (e.g., recruiting efforts at health fairs and contacts with nurses at other providers in the area);

(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.

(c) Waivers will remain effective for one year at a time.

(d) CMS may approve a maximum of two one-year extensions for each initial waiver. If a **hospice** wishes to receive a one-year extension, the **hospice** must submit a certification to CMS, prior to the expiration of the waiver period, that the employment market for nurses has not changed significantly since the time the initial waiver was granted.

[52 FR 7416, Mar. 11, 1987]

Sec. 418.84 Condition of participation--Medical social services.

Medical social services must be provided by a qualified social worker, under the direction of a physician.

Sec. 418.86 Condition of participation--Physician services.

In addition to palliation and management of terminal illness and related conditions, physician employees of the **hospice**, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.

Sec. 418.88 Condition of participation--Counseling services.

Counseling services must be available to both the individual and the family. Counseling includes bereavement counseling, provided after the patient's death as well as dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the **hospice**.

(a) Standard: Bereavement counseling. There must be an organized program

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for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient). A special coverage provision for bereavement counseling is specified Sec. 418.204(c).

(b) Standard: Dietary counseling. Dietary counseling, when required, must be provided by a qualified individual.

(c) Standard: Spiritual counseling. Spiritual counseling must include notice to patients as to the availability of clergy as provided in Sec. 418.70(f).

(d) Standard: Additional counseling. Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the **hospice**.

Subpart E--Conditions of Participation: Other Services

Sec. 418.90 Condition of participation--Furnishing of other services.

A **hospice** must ensure that the services described in this subpart are provided directly by **hospice** employees or under arrangements made by the **hospice** as specified in Sec. 418.56.

[48 FR 56026, Dec. 16, 1983, as amended at 55 FR 50835, Dec. 11, 1990]

Sec. 418.92 Condition of participation--Physical therapy, occupational therapy, and speech-language pathology.

(a) Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.

(b) (1) If the **hospice** engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the FDA, such testing must be in compliance with all applicable requirements of part 493 of this chapter.

(2) If the **hospice** chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.

[57 FR 7135, Feb. 28, 1992]

Sec. 418.94 Condition of participation-- Home health aide and homemaker services.

Home health aide and homemaker services must be available and adequate in frequency to meet the needs of the patients. A home health aide is a person who meets the training, attitude and skill requirements specified in Sec. 484.36 of this chapter.

(a) Standard: Supervision. A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services.

(b) Standard: Duties. Written instructions for patient care are prepared by a registered nurse. Duties include, but may not be limited to, the duties specified in Sec. 484.36(c) of this chapter.

[48 FR 56026, Dec. 16, 1983, as amended at 55 FR 50835, Dec. 11, 1990]

Sec. 418.96 Condition of participation--Medical supplies.

Medical supplies and appliances including drugs and biologicals, must be provided as needed for the palliation and management of the terminal illness and related conditions.

(a) Standard: Administration. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(b) Standard: Controlled drugs in the patient's home. The **hospice** must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient.

(c) Standard: Administration of drugs and biologicals. Drugs and biologicals are administered only by the following individuals:

(1) A licensed nurse or physician.

(2) An employee who has completed a State-approved training program

in medication administration.

(3) The patient if his or her attending physician has approved.

(4) Any other individual in accordance with applicable State and local

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laws. The persons, and each drug and biological they are authorized to administer, must be specified in the patient's plan of care.

Sec. 418.98 Condition of participation--Short term inpatient care.

Inpatient care must be available for pain control, symptom management and respite purposes, and must be provided in a participating Medicare or Medicaid facility.

(a) Standard: Inpatient care for symptom control. Inpatient care for pain control and symptom management must be provided in one of the following:

(1) A **hospice** that meets the condition of participation for providing inpatient care directly as specified in Sec. 418.100.

(2) A hospital or an SNF that also meets the standards specified in Sec. 418.100 (a) and (e) regarding 24-hour nursing service and patient areas.

(b) Standard: Inpatient care for respite purposes. Inpatient care for respite purposes must be provided by one of the following:

(1) A provider specified in paragraph (a) of this section.

(2) An ICF that also meets the standards specified in Sec. 418.100 (a) and (e) regarding 24-hour nursing service and patient areas.

(c) Standard: Inpatient care limitation. The total number of inpatient days used by Medicare beneficiaries who elected **hospice** coverage in any 12-month period preceding a certification survey in a particular **hospice** may not exceed 20 percent of the total number of **hospice** days for this group of beneficiaries.

(d) Standard: Exemption from limitation. Until October 1, 1986, any **hospice** that began operation before January 1, 1975 is not subject to the limitation specified in paragraph (c).

[48 FR 56026, Dec. 16, 1983, as amended at 55 FR 50835, Dec. 11, 1990]

Sec. 418.100 Condition of participation Hospices that provide inpatient care directly.

A **hospice** that provides inpatient care directly must comply with all of the following standards.

(a) Standard: Twenty-four-hour nursing services. (1) The facility provides 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient plan of care. Each patient receives treatments, medications, and diet as prescribed, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) Each shift must include a registered nurse who provides direct patient care.

(b) Standard: Disaster preparedness. The **hospice** has an acceptable written plan, periodically rehearsed with staff, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.

(c) Standard: Health and safety laws. The **hospice** must meet all

Federal, State, and local laws, regulations, and codes pertaining to health and safety, such as provisions regulating--

- (1) Construction, maintenance, and equipment for the **hospice**;
 - (2) Sanitation;
 - (3) Communicable and reportable diseases; and
 - (4) Post mortem procedures.
 - (d) Standard: Fire protection. (1) Except as provided in paragraphs (d) (2) and (3) of this section, the **hospice** must meet the provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference)¹ that are applicable to hospices.
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\1\ See footnote to Sec. 405.1134(a) of this chapter.

(2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship for the **hospice**, but only if the waiver would not adversely affect the health and safety of the patients.

(3) Any **hospice** that, on May 9, 1988, complies with the requirements of the 1981 edition of the Life Safety Code, with or without waivers, will be considered to be in compliance with this standard, as long as the **hospice** continues to remain in compliance with that edition of the Life Safety Code.

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(4) Any facility of two or more stories that is not of fire resistive construction and is participating on the basis of a waiver of construction type or height, may not house blind, nonambulatory, or physically handicapped patients above the street-level floor unless the facility--

(i) Is one of the following construction types (as defined in the Life Safety Code):

- (A) Type II (1, 1, 1)--protected non-combustible.
- (B) Fully sprinklered Type II (0, 0, 0)--non-combustible.
- (C) Fully sprinklered Type III (2, 1, 1)--protected ordinary.
- (D) Fully sprinklered Type V (1, 1, 1)--protected wood frame; or

(ii) Achieves a passing score on the Fire Safety Evaluation System (FSSES).

(e) Standard: Patient areas. (1) The **hospice** must design and equip areas for the comfort and privacy of each patient and family members.

(2) The **hospice** must have--

- (i) Physical space for private patient/family visiting;
- (ii) Accommodations for family members to remain with the patient throughout the night;
- (iii) Accommodations for family privacy after a patient's death; and
- (iv) Decor which is homelike in design and function.

(3) Patients must be permitted to receive visitors at any hour, including small children.

(f) Standard: Patient rooms and toilet facilities. Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients.

(1) Each patient's room must--

- (i) Be equipped with or conveniently located near toilet and bathing

facilities;

- (ii) Be at or above grade level;
- (iii) Contain a suitable bed for each patient and other appropriate furniture;
- (iv) Have closet space that provides security and privacy for clothing and personal belongings;
- (v) Contain no more than four beds;
- (vi) Measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multipatient room; and
- (vii) Be equipped with a device for calling the staff member on duty.

(2) For an existing building, CMS may waive the space and occupancy requirements of paragraphs (f)(1) (v) and (vi) of this section for as long as it is considered appropriate if it finds that--

- (i) The requirements would result in unreasonable hardship on the **hospice** if strictly enforced; and
- (ii) The waiver serves the particular needs of the patients and does not adversely affect their health and safety.

(g) Standard: Bathroom facilities. The **hospice** must--

(1) Provide an adequate supply of hot water at all times for patient use; and

(2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.

(h) Standard: Linen. The **hospice** has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(i) Standard: Isolation areas. The **hospice** must make provision for isolating patients with infectious diseases.

(j) Standard: Meal service, menu planning, and supervision. The **hospice** must--

(1) Serve at least three meals or their equivalent each day at regular times, with not more than 14 hours between a substantial evening meal and breakfast;

(2) Procure, store, prepare, distribute, and serve all food under sanitary conditions;

(3) Have a staff member trained or experienced in food management or nutrition who is responsible for--

(i) Planning menus that meet the nutritional needs of each patient, following the orders of the patient's physician and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences (Recommended Dietary Allowances (9th ed., 1981) is available from the Printing and Publications Office, National Academy of Sciences, Washington, DC 20418); and

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(ii) Supervising the meal preparation and service to ensure that the menu plan is followed; and

(4) If the **hospice** has patients who require medically prescribed special diets, have the menus for those patients planned by a professionally qualified dietitian and supervise the preparation and serving of meals to ensure that the patient accepts the special diet.

(k) Standard: Pharmaceutical services. The **hospice** provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained

from community or institutional pharmacists or stocked by the facility, the facility is responsible for drugs and biologicals for its patients, insofar as they are covered under the program and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws. (See Sec. 405.1124(g), (h), and (i) of this chapter.)

(1) Licensed pharmacist. The **hospice** must--

(i) Employ a licensed pharmacist; or

(ii) Have a formal agreement with a licensed pharmacist to advise the **hospice** on ordering, storage, administration, disposal, and recordkeeping of drugs and biologicals.

(2) Orders for medications. (i) A physician must order all medications for the patient.

(ii) If the medication order is verbal--

(A) The physician must give it only to a licensed nurse, pharmacist, or another physician; and

(B) The individual receiving the order must record and sign it immediately and have the prescribing physician sign it in a manner consistent with good medical practice.

(3) Administering medications. Medications are administered only by one of the following individuals:

(i) A licensed nurse or physician.

(ii) An employee who has completed a State-approved training program in medication administration.

(iii) The patient if his or her attending physician has approved.

(4) Control and accountability. The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility. Drugs are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled.

(5) Labeling of drugs and biologicals. The labeling of drugs and biologicals is based on currently accepted professional principles, and includes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.

(6) Storage. In accordance with State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention & Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. An emergency medication kit is kept readily available.

(7) Drug disposal. Controlled drugs no longer needed by the patient are disposed of in compliance with State requirements. In the absence of State requirements, the pharmacist and a registered nurse dispose of the drugs and prepare a record of the disposal.

[48 FR 56026, Dec. 16, 1983; 48 FR 57282, Dec. 29, 1983; 49 FR 23010, June 1, 1984, as amended at 53 FR 11509, Apr. 7, 1988; 55 FR 50835, Dec. 11, 1990]

Sec. 418.200 Requirements for coverage.

To be covered, **hospice** services must meet the following requirements. They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The individual must elect **hospice** care in accordance with Sec. 418.24 and a plan of care must be established as set forth in Sec. 418.58 before services

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are provided. The services must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in Sec. 418.22.

Sec. 418.202 Covered services.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered **hospice** services:

(a) Nursing care provided by or under the supervision of a registered nurse.

(b) Medical social services provided by a social worker under the direction of a physician.

(c) Physicians' services performed by a physician as defined in Sec. 410.20 of this chapter except that the services of the **hospice** medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

(d) Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

(e) Short-term inpatient care provided in a participating **hospice** inpatient unit, or a participating hospital or SNF, that additionally meets the standards in Sec. 418.202 (a) and (e) regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management.

Inpatient care may also be furnished as a means of providing respite for the individual's family or other persons caring for the individual at home. Respite care must be furnished as specified in Sec. 418.98(b). Payment for inpatient care will be made at the rate appropriate to the level of care as specified in Sec. 418.302.

(f) Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as described in Sec. 410.38 of this chapter as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the **hospice** for use in the patient's home while he or she is under **hospice** care. Medical supplies include those that are part of the written plan of care.

(g) Home health aide services furnished by qualified aides as designated in Sec. 418.94 and homemaker services. Home health aides may provide personal care services as defined in Sec. 409.45(b) of this chapter. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.

(h) Physical therapy, occupational therapy and speech-language pathology services in addition to the services described in Sec. 409.33 (b) and (c) of this chapter provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.

[48 FR 56026, Dec. 16, 1983, as amended at 51 FR 41351, Nov. 14, 1986; 55 FR 50835, Dec. 11, 1990; 59 FR 65498, Dec. 20, 1994]

Sec. 418.204 Special coverage requirements.

(a) Periods of crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis but

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care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

(b) Respite care. (1) Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.

(2) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

(c) Bereavement counseling. Bereavement counseling is a required **hospice** service but it is not reimbursable.

[48 FR 56026, Dec. 16, 1983, as amended at 55 FR 50835, Dec. 11, 1990]

Subpart G--Payment for **Hospice** Care

Sec. 418.301 Basic rules.

(a) Medicare payment for covered **hospice** care is made in accordance with the method set forth in Sec. 418.302.

(b) Medicare reimbursement to a **hospice** in a cap period is limited to a cap amount specified in Sec. 418.309.

[48 FR 56026, Dec. 16, 1983, as amended at 56 FR 26919, June 12, 1991]

Sec. 418.302 Payment procedures for **hospice** care.

(a) CMS establishes payment amounts for specific categories of covered **hospice** care.

(b) Payment amounts are determined within each of the following categories:

(1) Routine home care day. A routine home care day is a day on which an individual who has elected to receive **hospice** care is at home and is not receiving continuous care as defined in paragraph (b) (2) of this section.

(2) Continuous home care day. A continuous home care day is a day on which an individual who has elected to receive **hospice** care is not in an inpatient facility and receives **hospice** care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in Sec. 418.204(a) and only as necessary to maintain the terminally ill patient at home.

(3) Inpatient respite care day. An inpatient respite care day is a day on which the individual who has elected **hospice** care receives care in an approved facility on a short-term basis for respite.

(4) General inpatient care day. A general inpatient care day is a day on which an individual who has elected **hospice** care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

(c) The payment amounts for the categories of **hospice** care are fixed payment rates that are established by CMS in accordance with the procedures described in Sec. 418.306. Payment rates are determined for the following categories:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

(d) The intermediary reimburses the **hospice** at the appropriate payment amount for each day for which an eligible Medicare beneficiary is under the **hospice's** care.

(e) The intermediary makes payment according to the following procedures:

(1) Payment is made to the **hospice** for each day during which the beneficiary is eligible and under the care of the **hospice**, regardless of the amount of services furnished on any given day.

(2) Payment is made for only one of the categories of **hospice** care described in Sec. 418.302(b) for any particular day.

(3) On any day on which the beneficiary is not an inpatient, the **hospice** is paid the routine home care rate, unless the patient receives continuous care as defined in paragraph (b) (2) of this section for a period of at least 8 hours. In that case, a portion of the continuous care day rate is paid in accordance with paragraph (e) (4) of this section.

(4) The **hospice** payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous care provided during a continuous

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home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of 8 hours of care must be furnished on a particular day to qualify for the continuous home care rate.

(5) Subject to the limitations described in paragraph (f) of this

section, on any day on which the beneficiary is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care furnished. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the beneficiary is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day. Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

(f) Payment for inpatient care is limited as follows: (1) The total payment to the **hospice** for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicare patients not exceed 20 percent of the total days for which these patients had elected **hospice** care.

(2) At the end of a cap period, the intermediary calculates a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of **hospice** care furnished to Medicare patients.

(3) If the number of days of inpatient care furnished to Medicare patients is equal to or less than 20 percent of the total days of **hospice** care to Medicare patients, no adjustment is necessary. Overall payments to a **hospice** are subject to the cap amount specified in Sec. 418.309.

(4) If the number of days of inpatient care furnished to Medicare patients exceeds 20 percent of the total days of **hospice** care to Medicare patients, the total payment for inpatient care is determined in accordance with the procedures specified in paragraph (f)(5) of this section. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the **hospice**. Overall payments to the **hospice** are subject to the cap amount specified in Sec. 418.309.

(5) If a **hospice** exceeds the number of inpatient care days described in paragraph (f)(4), the total payment for inpatient care is determined as follows:

(i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the **hospice** to Medicare patients.

(ii) Multiply this ratio by the total reimbursement for inpatient care made by the intermediary.

(iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(iv) Add the amounts calculated in paragraphs (f)(5)(ii) and (iii) of this section.

[48 FR 56026, Dec. 16, 1983, as amended at 56 FR 26919, June 12, 1991]

Sec. 418.304 Payment for physician services.

(a) The following services performed by **hospice** physicians are included in the rates described in Sec. 418.302:

(1) General supervisory services of the medical director.

(2) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and

establishment of governing policies by the physician member of the interdisciplinary group.

(b) For services not described in paragraph (a) of this section, a specified Medicare contractor pays the **hospice** an amount equivalent to 100 percent of the physician's reasonable charge for those physician services furnished by **hospice** employees or under arrangements with the **hospice**. Reimbursement for these physician services is included in the amount subject to the **hospice** payment limit described in Sec. 418.309. Services furnished voluntarily by physicians are not reimbursable.

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(c) Services of the patient's attending physician, if he or she is not an employee of the **hospice** or providing services under arrangements with the **hospice**, are not considered **hospice** services and are not included in the amount subject to the **hospice** payment limit described in Sec. 418.309. These services are paid by the carrier under the procedures in subparts D or E, part 405 of this chapter.

Sec. 418.306 Determination of payment rates.

(a) Applicability. CMS establishes payment rates for each of the categories of **hospice** care described in Sec. 418.302(b). The rates are established using the methodology described in section 1814(i)(1)(C) of the Act.

(b) Payment rates. The payment rates for routine home care and other services included in **hospice** care are as follows:

(1) The following rates, which are 120 percent of the rates in effect on September 30, 1989, are effective January 1, 1990 through September 30, 1990 and October 21, 1990 through December 31, 1990:

Routine home care.....	\$75.80
Continuous home care:	
Full rate for 24 hours.....	442.40
Hourly rate.....	18.43
Inpatient respite care.....	78.40
General inpatient care.....	337.20

(2) Except for the period beginning October 21, 1990, through December 31, 1990, the payment rates for routine home care and other services included in **hospice** care for Federal fiscal years 1991, 1992, and 1993 and those that begin on or after October 1, 1997, are the payment rates in effect under this paragraph during the previous fiscal year increased by the market basket percentage increase as defined in section 1886(b)(3)(B)(iii) of the Act, otherwise applicable to discharges occurring in the fiscal year. The payment rates for the period beginning October 21, 1990, through December 31, 1990, are the same as those shown in paragraph (b)(1) of this section.

(3) For Federal fiscal years 1994 through 1997, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase minus--

- (i) 2 percentage points in FY 1994;
- (ii) 1.5 percentage points in FYs 1995 and 1996; and
- (iii) 0.5 percentage points in FY 1997.

(c) Adjustment for wage differences. CMS will issue annually, in the Federal Register, a **hospice** wage index based on the most current

available CMS hospital wage data, including any changes to the definitions of Metropolitan Statistical Areas. The payment rates established by CMS are adjusted by the intermediary to reflect local differences in wages according to the revised wage index.

(d) Federal Register notices. CMS publishes as a notice in the Federal Register any proposal to change the methodology for determining the payment rates.

[56 FR 26919, June 12, 1991, as amended at 59 FR 26960, May 25, 1994; 62 FR 42882, Aug. 8, 1997]

Sec. 418.307 Periodic interim payments.

Subject to the provisions of Sec. 413.64(h) of this chapter, a **hospice** may elect to receive periodic interim payments (PIP) effective with claims received on or after July 1, 1987. Payment is made biweekly under the PIP method unless the **hospice** requests a longer fixed interval (not to exceed one month) between payments. The biweekly interim payment amount is based on the total estimated Medicare payments for the reporting period (as described in Secs. 418.302-418.306). Each payment is made 2 weeks after the end of a biweekly period of service as described in Sec. 413.64(h)(5) of this chapter. Under certain circumstances that are described in Sec. 413.64(g) of this chapter, a **hospice** that is not receiving PIP may request an accelerated payment.

[59 FR 36713, July 19, 1994]

Sec. 418.308 Limitation on the amount of **hospice** payments.

(a) Except as specified in paragraph (b) of this section, the total Medicare payment to a **hospice** for care furnished during a cap period is limited by the **hospice** cap amount specified in Sec. 418.309.

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(b) Until October 1, 1986, payment to a **hospice** that began operation before January 1, 1975 is not limited by the amount of the **hospice** cap specified in Sec. 418.309.

(c) The intermediary notifies the **hospice** of the determination of program reimbursement at the end of the cap year in accordance with procedures similar to those described in Sec. 405.1803 of this chapter.

(d) Payments made to a **hospice** during a cap period that exceed the cap amount are overpayments and must be refunded.

[48 FR 56026, Dec. 16, 1983; 48 FR 57282, Dec. 29, 1983]

Sec. 418.309 **Hospice** cap amount.

The **hospice** cap amount is calculated using the following procedures:

(a) The cap amount is \$6,500 per year and is adjusted for inflation or deflation for cap years that end after October 1, 1984, by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year. The cap year runs from November 1 of each year until October 31 of the following year.

(b) Each **hospice**'s cap amount is calculated by the intermediary by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries who elected to receive **hospice** care from that **hospice** during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes--

(1) Those Medicare beneficiaries who have not previously been included in the calculation of any **hospice** cap and who have filed an election to receive **hospice** care, in accordance with Sec. 418.24, from the **hospice** during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).

(2) In the case in which a beneficiary has elected to receive care from more than one **hospice**, each **hospice** includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stay in all hospices that was spent in that **hospice**. (The **hospice** can obtain this information by contacting the intermediary.)

Sec. 418.310 Reporting and recordkeeping requirements.

Hospices must provide reports and keep records as the Secretary determines necessary to administer the program.

Sec. 418.311 Administrative appeals.

A **hospice** that believes its payments have not been properly determined in accordance with these regulations may request a review from the intermediary or the Provider Reimbursement Review Board (PRRB) if the amount in controversy is at least \$1,000 or \$10,000, respectively. In such a case, the procedure in 42 CFR part 405, subpart R, will be followed to the extent that it is applicable. The PRRB, subject to review by the Secretary under Sec. 405.1874 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the payment rates by CMS are not subject to appeal.

Subpart H--Coinsurance

Sec. 418.400 Individual liability for coinsurance for **hospice** care.

An individual who has filed an election for **hospice** care in accordance with Sec. 418.24 is liable for the following coinsurance payments. Hospices may charge individuals the applicable coinsurance amounts.

(a) Drugs and biologicals. An individual is liable for a coinsurance payment for each palliative drug and biological prescription furnished by the **hospice** while the individual is not an inpatient. The amount of coinsurance for each prescription approximates 5 percent of the cost of the drug or biological to the **hospice** determined in accordance with the drug copayment schedule established by the **hospice**, except that the amount of coinsurance for each prescription may not exceed \$5. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances.

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The drug copayment schedule must be reviewed for reasonableness and

approved by the intermediary before it is used.

(b) Respite care. (1) The amount of coinsurance for each respite care day is equal to 5 percent of the payment made by CMS for a respite care day.

(2) The amount of the individual's coinsurance liability for respite care during a **hospice** coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the **hospice** coinsurance period began.

(3) The individual **hospice** coinsurance period--

(i) Begins on the first day an election filed in accordance with Sec. 418.24 is in effect for the beneficiary; and

(ii) Ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

Sec. 418.402 Individual liability for services that are not considered **hospice** care.

Medicare payment to the **hospice** discharges an individual's liability for payment for all services, other than the **hospice** coinsurance amounts described in Sec. 418.400, that are considered covered **hospice** care (as described in Sec. 418.202). The individual is liable for the Medicare deductibles and coinsurance payments and for the difference between the reasonable and actual charge on unassigned claims on other covered services that are not considered **hospice** care. Examples of services not considered **hospice** care include: Services furnished before or after a **hospice** election period; services of the individual's attending physician, if the attending physician is not an employee of or working under an arrangement with the **hospice**; or Medicare services received for the treatment of an illness or injury not related to the individual's terminal condition.

Sec. 418.405 Effect of coinsurance liability on Medicare payment.

The Medicare payment rates established by CMS in accordance with Sec. 418.306 are not reduced when the individual is liable for coinsurance payments. Instead, when establishing the payment rates, CMS offsets the estimated cost of services by an estimate of average coinsurance amounts hospices collect.

[56 FR 26919, June 12, 1991]